

EXECUTIVE SUMMARY

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During January through April 2010 a series of informational interviews was conducted with 105 stakeholders in Skagit County to determine the current status of access to healthcare, particularly for the uninsured and other populations that face barriers and challenges to access. This assessment was commissioned by the Skagit County Alliance for Healthcare Access (SCAHA), a group of representatives from twenty health and social service organizations that serve Skagit County along with county government representation. This report contains factual information obtained from public sources, summary information gained from the interviewees, and observations and recommendations from the consultant based on national experience with similar assessments and national best practices from other communities. The assessment report is intended to inform a subsequent written plan of action that will drive improved access to healthcare in the county and will position the county to thrive as healthcare reform and other external factors change the environment for the delivery of healthcare.

The interviews conducted for this assessment paint a picture of a relatively resource rich community with many elements of a strong healthcare safety net system already in place. These assets include:

- Some local funding to support healthcare including two special purpose hospitals districts that receive revenue from property tax levies to support operations. A third special hospital district has a taxpayer voted General Obligation Bond Debt to support construction of the new addition to the hospital. It receives revenue from an assessment on real property each year that is used to pay the principal and interest on the bonds until they are paid off. Together the 3 hospitals received nearly \$8 million dollars through these mechanisms in FY 2008. All of these hospitals are non-profit organizations and by virtue of this public funding mechanism are accountable to the citizens of the county for the quality and effectiveness of the healthcare system. All hospitals have adopted the Washington State Hospital Association's guidelines for charity care and discounted fees for low income patients. Additionally, there is a 1/10 of 1% county sales tax that provides approximately \$2 million annually to fund some mental health and chemical dependency services.
- A state Medicaid program and Basic Health program with relatively generous eligibility criteria that allow free or subsidized Medicaid coverage for children up to 300% of Federal Poverty Level (FPL), pregnant women up to 185% of FPL, and of some adults up to 50% of FPL. While pregnant women who were not citizens have been able to access coverage in the past, a new citizenship requirement is being implemented. The Basic Health program provides subsidized coverage of adults or children up to 200% of FPL, though this program is currently closed to new enrollment due to state budget shortfalls.
- A Federally Qualified Health Center (FQHC) with five service locations, six designated Rural Health Centers (RHC's), two tribal health clinics, a Veterans Affairs Clinic, and five reproductive health clinics. The FQHC's, RHC's and tribal clinics receive enhanced reimbursement to provide care to Medicaid and Medicare populations and may have access to various grant funds to support care of uninsured populations. The FQHC recently received expansion grants that will allow expansion of primary care, dental and behavioral health services.
- A private medical community that includes several primary care and specialty practices that are willing to serve Medicaid and some uninsured patients and some that offer sliding scale fees to low income patients.

- Some elements of an oral health care system for low income patients that includes services at the FQHC, one tribal clinic, two dental vans, a sealant program through the Public Health Department in cooperation with the schools, and a few private dentists that are open to both Medicaid and uninsured patients.
- A strong community action agency that administers over thirty health and social service programs for low income individuals and serves to some extent as a one-stop shop for the vulnerable population to get connected to services.
- A vibrant public health department that, despite recent budget cuts, remains actively engaged in a variety of collaborative efforts to improve community health in addition to the direct services that it provides.
- Some history of collaborative efforts among health care providers including a joint hospice service, a physical activity coalition, a collaboration among hospitals and clinics to explore the possibility of sharing electronic health records among all providers, and of course, the SCAHA.

These interviews also revealed several opportunities for improvement in the health care safety net system:

- Almost all interviewees revealed a surprising lack of knowledge about what services existed in the county and about how to access services. There is no comprehensive, current directory of resources though at least three different organizations produce some sort of resource guide periodically. There is almost no awareness of the 211 information and referral system that is available by phone or on-line. Many misperceptions and much erroneous information exist about what services are available and about the best way to refer clients or patients to receive services.
- There are no resources dedicated to “navigation” of the health care system for vulnerable patients who may require assistance. Referrals are made among hospitals, emergency departments, physicians, and other services with no mechanism to assure that the “hand off” was accomplished and follow up care was received.
- In spite of the existence of some safety net dental services, there is not nearly enough capacity, especially for low income adults. Waiting lists for service are many months long, and use of Emergency Departments for dental crises is common. The dental van services are not effectively deployed, offering limited service with much confusion about how patients can access the service and about when or where the service will be offered.
- Recent state budget cuts for behavioral health and chemical dependency services seem to have created much chaos in the community. Most interviewees expressed the opinion that there are really no services available at all anymore, or that what few services still exist have waiting lists that are so long there is no reason to even refer a patient. There were also concerns expressed about the quality of services available at some behavioral health providers. Emergency Departments, especially at Skagit Valley Hospital see many patients with mental health crises that have very long lengths of stay while waiting for placement in an appropriate level of care, with some being discharged without appropriate placement. Finally, while public (Medicaid and county) funding does exist for some crisis and high level services, there is almost no availability of routine behavioral health services such as counseling and ongoing medication management for low income individuals.
- Many health and social services providers offer some kind of assistance with access to prescription drugs for low income patients without coverage for drugs, but these services are not optimized. There is some use of samples, the \$4.00 retail programs, the manufacturers’ free drug programs, vouchers, and free websites, but no provider makes use of all the tactics, and most providers offer assistance on a random basis – “if a staff

member has extra time". No provider is using available purchased or licensed software programs to maximize the effectiveness of manufacturers' free drug programs.

- The use of Sea Mar Community Health Center (Sea Mar), the only FQHC, does not seem to be optimized in the community. There are strong perceptions among interviewees that there are many patients for whom a referral to Sea Mar would be inappropriate, particularly any non-Hispanic patient. There are also perceptions that the service provided at the clinic is less than desirable and that there is no capacity for new patients. Unusually, these perceptions exist in spite of a strong perception that the physicians at Sea Mar are very high quality and the fact that the new Sea Mar location at Skagit Valley Hospital is operating at only 70% of capacity.
- While there are Urgent Care clinics in the county, there are very limited services available in the evening and weekend hours. No clinics are available after 9 pm on weekdays or 5 pm on weekends. This gap in services was cited as a significant concern by several interviewees and one that disproportionately affects low income individuals who are more likely to be unable to access health care services during usual working hours.
- While there is some access to specialty physician care for the uninsured and indigent, it is through an informal system that depends on relationships and phone calls between providers. Access to orthopedic care is the exception in that interviewees report that no orthopedic surgeons in Skagit County will accept a referral for uninsured or indigent patients and many of these patients are referred out of the county for care.
- Many interviewees mentioned challenges with serving new immigrant populations of Indigenous Peoples of Mexico, Russian, and Eastern European populations. Little formal cultural competence training seems to have been offered in the community. There are some challenges with availability of certified medical interpreters for these new populations, and with the cost of existing interpretation services.
- The communities in the Eastern half of the county are served by a single physician. Interviewees expressed concerns about the lack of choice in health care providers, some uncertainty about the quality of care available to them, and great concerns about transportation challenges with getting to health and social services that are only available in the Western half of the county or in Bellingham or Seattle. Very few organizations offer routine outreach services in these communities. There is also no community- or county-wide planning effort dedicated to identifying a health care delivery system for the future, after the single practicing physician retires.

All of the opportunities for improvement can be addressed by a collaborative effort of health care providers, social service providers, and city and county governments. Recommendations for a specific approach are made at the end of this report. It will be critical that a highly visible group of community leaders including hospital CEO's and city and county government leaders commission this work and accept accountability for the success of any initiatives.

There is strong infrastructure to build on and while it will be beneficial to hire a paid staff person as a director and coordinator of the recommended efforts, it should not be necessary to create a new organization or hire new staff in addition to the one director. A formal coalition such as SCAHA can work to identify funding and other resources and build on the services of existing organizations to operationalize the recommendations to improve the healthcare safety net in Skagit County. The most challenging improvement effort is likely to be in the arena of mental health services, but this county is as well positioned as any in the country to create new effective models of care for this vulnerable population.

By accepting the challenge of improving access to healthcare for all Skagit County residents at this time, the three public hospitals and the city and county governments have a unique

opportunity to showcase the power of collaboration, to deliver on their accountability to the taxpayers who support their efforts, and to position Skagit County to thrive in a future where integration, collaboration, and efficient high quality systems of care will be required and rewarded by public and private payers.